Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LANDMARK MEDICAL
DIVISION OF DYNASPLINT SYSTEMS, INC.
770 RITCHIE HIGHWAY 2-21
SEVERNAPARK MD 21146-3937

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-04-0861-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Sole provider & manufacturer of Dynasplint."

Amount in Dispute: $640.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears that the Requestor is seeking reimbursement when certain charges were paid, reduced or denied in accordance with the Medical Fee Guidelines. The Respondent is of the position that its payments and reductions were appropriate, and seeks an order denying further payments to Requestor."

Response Submitted by: Harris & Harris, PO BOX 162443 Westlake Station, Austin, TX 78716-2443

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2002 August 8, 2002 September 8, 2002	HCPCS Code L3960	$405.00	$0.00
October 8, 2002	HCPCS Code L3960	$235.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the medical fee guideline for professional medical services provided on or after September 1, 2002.
3. This request for medical fee dispute resolution was received by the Division on September 18, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), amended to be effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 24, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 8, 2002
   - M – No MAR set by TWCC-reduced to fair and reasonable. Allowance without supply house invoice.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(d)(1), amended to be effective January 1, 2003, 27 *Texas Register* 12282, a request for medical dispute resolution shall be considered timely if it is filed with the division no later than one (1) year after the dates of service in dispute. Dates of service July 8, 2002 through September 8, 2002 were not filed in a timely manner and will not be considered in this review. Date of service, October 8, 2002 was filed in a timely manner and will be reviewed in accordance with applicable Division rules.
2. 28 Texas Administrative Code §134.202(c), adopted to be effective May 16, 2002, Volume 27 *Texas Register*, page 4048 states, in pertinent part, that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:... (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule. Per the Medicare DMEPOS fee schedule, effective for October 2002 for the state of Texas, HCPCS code L3960 had a Medicare fee of $652.87. Medicare payment policy allows for the rental of code L3960 in accordance with Section 1834 [42 USC 1395m] (a)(7)(A)(i)(II), which states that "the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price." Review of the submitted documentation finds that the rental month in dispute falls after the initial three months of the rental period; therefore, the rental amount is 7.5% of the purchase price for the item. Reimbursement is calculated as follows: 7.5% of the Medicare fee of $652.87 is $48.97. This amount multiplied by the Division conversion factor of 125% yields a maximum allowable reimbursement (MAR) amount of $61.21. This amount less the amount previously paid by the insurance carrier of $235.00 leaves an amount due to the provider of $0.00. No additional payment can be recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 3, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.